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ABSTRACT

In 1985, the New York City Health Care for the Homeless Program began providing health care and social services to homeless people. The program seeks to provide care to those homeless people with the least access to services, reaching out to them in soup kitchens, shelters, and hotels. This paper summarizes what has been learned since 1985 about the special needs of homeless people and about the difficulties of providing services to this disaffiliated and vulnerable population. The report contains four principal sections. The first section, "Who Are America's Homeless?" identifies the major groups of single adults, families, and youth. The second section, "One Response: The New York City Health Care for the Homeless Program," describes the design and history of the program, its biggest challenges, and the support of the outreach staff. The third section, "Holes in the Safety Net," reviews obstacles to providing care, including site limitations, reluctance to receive care, staffing changes, institutional aversion, and lack of facilities. The fourth section, "Implications for Public Social Policy," examines issues underlying homelessness, including racism, mental illness, substance abuse, HIV-related illnesses, and housing needs. The paper includes statistical data in six tables and charts and a list of 17 references. (AF)

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Homeless People and Health Care: An Unrelenting Challenge

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HOMELESS PEOPLE AND HEALTH CARE: AN UNRELENTING CHALLENGE

Susan L. Neibacher
Project Director
New York City Health Care for the Homeless Program

United Hospital Fund of New York

December 1990

The author wishes to thank Bruce C. Vladeck and J. David Seay for their support of the New York City Health Care for the Homeless Program. They and the entire staff of the program who serve homeless people, especially Kathryn Ralph and G. Robert Watts, my colleagues here at the Fund, provided support and insights reflected in this paper. Special and grateful appreciation is expressed to Phyllis Brooks for her untiring and patient editing, good humor, and commitment to getting this paper published.

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FOREWORD

At the United Hospital Fund, we demonstrate our concern about health care policy, financing, and access through our research projects, philanthropic programs, and information services, but our role can tend to be somewhat removed from the day-to-day struggles of health care and social service providers. This changed in 1985, when, in a departure from tradition, the Fund agreed to administer the New York City Health Care for the Homeless Program, one of 19 programs nationwide funded originally by the Robert Wood Johnson Foundation and Pew Charitable Trusts to provide health and social services to those homeless people with least access to care. Today, support is provided by the U.S. Public Health Service and the special efforts of Comic Relief.

The program, which sends interdisciplinary teams to soup kitchens and shelters around the city, has broadened our knowledge of the plight of homeless people and made us more keenly aware of the difficulties of serving them. Data collected by the program confirm what many of us suspected: homeless people's problems often begin long before they become homeless and these problems are not so much the result of personal shortcomings as of broad social forces. Cutbacks in social programs, changes in the labor market, family disintegration, increased dispersion of income and wealth, and various forms of discrimination--all of these factors have led to the growing entrenchment of a homeless population.

Overseen by a coalition of health care and social service providers and advocates, the New York City Health Care for the Homeless Program has an impressive record of reaching homeless people. Last year alone, it provided care to almost 8,000 homeless people in 20,000 treatment encounters. Much of the program's success may be traced to the efforts of Susan L. Neibacher, the author of this paper. As one of the original members of the New York City Coalition for Health Care for the Homeless and as project director for the New York City Health Care for the Homeless Program for the last five years, she has devoted extraordinary energy and talent to the problems of serving the homeless in this city.

The Fund's commitment to solving the problems of the homeless began back in 1985, when we sponsored our first conference about the health care needs of homeless people. This conference led to a book, *Health Care of Homeless People*, which was edited by the Fund's long-time friend and partner in these subjects, Philip W. Brickner, M.D., director of the Department of Community Medicine at St. Vincent's Hospital and Medical Center of New York. The Fund reconvened some of these providers and advocates in 1987 for *Health Care for Homeless People: The Challenge for Health Care Providers*, a conference that it cosponsored with Columbia University Community Services and the New York City Coalition for Health Care for the Homeless. This conference was followed in 1988 by *Health Care for Homeless People: A Continuing Challenge*. This fall, in collaboration with W.W. Norton & Co., we published *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*, edited by Dr. Brickner, and sponsored a conference of the same title. With a grant from The Children's Health Fund, we recently prepared a directory of health care and social services for homeless families, which was distributed to 1,500 hospitals, health centers, and social service providers around the city.

This paper would not have been possible without grants from the New York Community Trust and Comic Relief. For this support, we are most grateful.

Bruce C. Vladeck
President
United Hospital Fund of New York

INTRODUCTION

In 1985, the New York City Health Care for the Homeless Program began providing health care and social services to homeless people. Funded originally by the Robert Wood Johnson Foundation and Pew Charitable Trusts and currently by the U.S. Public Health Service and other local sources, this program seeks to provide care to those homeless people with the least access to services, reaching out to them in soup kitchens, shelters, and hotels. This paper summarizes what has been learned since 1985 about the special needs of homeless people and about the difficulties of providing services to this disaffiliated and vulnerable population. In distilling the lessons of the last five years, however, one central irony emerges: although the program provides desperately needed services, it cannot begin to solve the problem of homelessness itself. Indeed, homelessness is fast becoming an almost intractable problem, with deep roots in the way American society is structured. Until we as a society are prepared to take a hard look at some of the inequities built into our social system, the number of homeless will continue to grow. In the meantime, health care and social service providers will continue their heroic but often futile attempts to apply band-aids to gaping wounds.

WHO ARE AMERICA'S HOMELESS?

Homelessness is not a new phenomenon in this country. Even in colonial days, the number of "wandering poor" was great enough that towns in Massachusetts developed a policy for "warning" them away.[1] Since then, the number of homeless people in the United States has risen and fallen, reaching a peak in the Great Depression of the 1930s, when there were as many as 1.5 million homeless people.[2] In the last decade, the number of homeless people has once again drastically increased, reflecting myriad social and economic changes.

But despite the growing numbers, counting the homeless is a formidable task, as demonstrated most recently by the 1990 census. Many homeless people are visible on the streets and in the parks and subways, but others hide from--or are invisible to--those seeking to count them. Estimates of the number of homeless people in the United States range from less than 200,000[3] to over two million.[4] These discrepant counts reflect varying definitions of "homeless" and different methods of enumeration. The methodological problems are compounded by the fact that many poor people move in and out of homeless status.

As the number of homeless people grows, so too does the heterogeneity of the population. Except during the Great Depression, homeless people have tended to be white, alcoholic, middle-aged men. Today the population includes single men and women of all ages, from all racial and ethnic backgrounds. Youth constitute a greater proportion of the homeless population than ever before, and homeless families are the fastest growing group across the country. No longer found only on skid rows in large cities, homeless people are now dispersed in cities and towns across the country, living in parks; on the streets; in the transportation system; in shelters, rescue missions, and welfare hotels; in abandoned buildings and cars; and doubled or tripled up in substandard housing.

Because services and funding streams tend to target specific subgroups of homeless people--single males, families headed by women, or teenagers, for example--it is all too easy to lose sight of the characteristics that homeless people have in common. In New York City, as across the country, homelessness is disproportionately a problem of minorities, and studies indicate that homeless people's lives are disrupted long before they become homeless. In one study of homeless people in New York City, 22 percent had grown up in foster care, institutions, or group homes; 25 percent had run away from home;[5] and a significant number had been physically or sexually abused as children.[6] These statistics argue powerfully that the causes of homelessness--and the cures--are far from simple.

Single Adults

Homeless single adults are the largest, and most undercounted, group of homeless people. New York City's public welfare agency, the Human Resources Administration (HRA), housed an average of 9,342 single adults per night in 1989, with a peak night of 11,061.[7] These sheltered single adults represent an unknown proportion of homeless singles.

In addition to having a roof over their head, those who live in municipal shelters, missions, or church or voluntary shelters receive food, clothing, showers, and toiletries. Those who stay on the streets are more likely to lack a regular supply of food and clothing and tend to be sicker and weaker than those whose living arrangements are relatively more stable. A 1985 study of 1,400 single adults in the HRA shelter system found that the reasons most commonly cited by shelter residents for their homelessness were conflicts with family or friends (35 percent), eviction or inability to pay the rent (22 percent), and drug or alcohol problems (11 percent).[8] Experience suggests that substance abuse plays an even larger role in precipitating homelessness than these figures indicate.

Families

While homeless families in rural areas may be headed by both a mother and a father, most homeless families in large urban areas are headed by single women. In New York City on March 16, 1990, for example, there were 3,688 homeless families in the HRA system, with an average size of 3.17 people. Of these families, the majority were headed by a single woman.[9]

The causes of homelessness among families are complex. One major study suggests that families seeking shelter in New York City become homeless not because they have lost housing but because they never had their own apartment to begin with. Comparing homeless families seeking shelter with persons on public assistance, the study found that 90 percent of families were on public assistance; most of them had been doubled up with friends or family but had left because of an argument. Only 18 percent of the families had been the primary tenant at the place they stayed the previous night, and 40 percent had never been a primary tenant for as long as one year. More than half of the families reported that they had lived in more than two residences in the year prior to seeking shelter. In addition, the study found that those families seeking shelter were significantly younger than those on public assistance, and more than half of them were black. Thirty-one percent had used the shelter system before.[10]

Other factors contribute to homelessness among families, most notably pregnancy. Among those women seeking shelter, 35 percent were pregnant and 26 percent had given birth within the last year.[11] These numbers are significantly higher than those for families on public assistance.

In New York City, homeless families are initially lodged in congregate shelters operated by HRA, where several families live in one room, before being moved to welfare hotels* or transitional family (Tier II) shelters, where each family has its own space and which are operated by voluntary agencies or by HRA. Once families are in the system, they become eligible for permanent housing.

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* New York City had hoped to stop placing homeless families in welfare hotels by June 1990 but was forced to reopen some of the hotels it had closed in order to accommodate the upsurge in families seeking shelter over the summer.

Although not all welfare hotels are as squalid as those depicted on television and in the press, rooms are crowded and lack legal cooking facilities. Often several families on a floor must share a single bathroom. Children have no room to crawl, play, learn to walk, or explore. While the city attempts to ensure that children remain in school, the children are often tired from lack of sleep due to cramped quarters and noise in the hotel. For these children, attention spans are short and absences are higher than usual. While it is too soon to know the long-term effects of homelessness on children, a number of studies have documented developmental lags and emotional problems.[12] A tragedy of many homeless families is that mothers come into the system drug-free but turn to drugs to escape their sordid surroundings. Trapped in these conditions, parents and children are often too depressed and disoriented to take advantage of services offered to them.

Youth

One coalition for homeless and runaway youth estimates that 25,000 of the homeless in New York State are under 21 years of age.[13] Most are ill equipped to function as independent adults and are particularly prone to exploitation in a city as vast and scary as New York. Almost all of those on the streets survive through high-risk behavior such as prostitution and selling drugs.

Like homeless adults, most homeless youth are from broken homes, many have been in foster care and have been discharged to their own responsibility, and some are "throwaways," a term as ugly as the condition it describes. One study characterizes these youth as coming primarily from single-parent families where poverty, medical problems, domestic violence, and emotional instability made family life chaotic.[14]

* * *

Regardless of age, race, or family status, homeless people tend to be sicker than the domiciled. They are exposed to the elements, often malnourished, and frequently the victims of violent attack. Proof of this may be found in the large number of treatment encounters for lacerations, abrasions, and fractures in one national program.[15] Many homeless people are substance abusers, at high risk of HIV infection because they share needles and engage in unprotected sexual activity. Other acute ailments commonly experienced by homeless people include upper respiratory infections and minor skin conditions. Chronic health disorders include hypertension, gastrointestinal disorders, peripheral vascular disease, poor dentition, and neurological disorders. It is estimated that the prevalence of tuberculosis is 25 times higher than among housed people.[16] Estimates of the proportion of homeless people suffering from mental health problems hover around 30 percent;[17] there is widespread agreement that mental health problems both lead to and are exacerbated by homelessness.

ONE RESPONSE: THE NEW YORK CITY HEALTH CARE FOR THE HOMELESS PROGRAM

Designing the Program

In 1985, the Robert Wood Johnson Foundation and Pew Charitable Trusts, together with the U.S. Conference of Mayors, established the national Health Care for the Homeless Program. Under the terms of the program, the 51 largest cities in the United States were eligible to apply for funding to provide health and social services to homeless people. In response to this request for proposals, the New York City Coalition for Health Care for the

Homeless was formed. Composed of representatives from approximately 25 public and private agencies committed to serving homeless persons, the coalition met to discuss the design of the program, taking into consideration existing health and social services for homeless people in the city, the particular needs of those homeless people deemed most lacking in services, and the availability of funding.

Access to care was first among the coalition's concerns. Lack of primary care is a problem in poor communities throughout New York City. Health care institutions in the city are already overwhelmed by poorer, sicker patients; insufficient reimbursement; and a health personnel shortage. Many institutions are so much under siege that people must wait weeks for appointments, and some health centers have been forced to close their registration because of oversubscription. Under these strained circumstances, seeking care can be a daunting experience, even for those not already overwhelmed by losses and change. Getting appointments in clinics in depressed neighborhoods requires things often taken for granted, for example, access to phones, which are simply not available in the poorest neighborhoods. As a result, even many domiciled New Yorkers neglect health care until an emergency arises.

Access to care is further complicated for homeless people, because they are most often displaced from their neighborhood of origin. While many homeless people seek shelter and food provided by a network of emergency service providers, they tend not to seek health or social services. They are unlikely to travel back to the hospital clinic or health center that they may have used when housed. This is especially true of mothers with young children, for whom traveling by public transportation through several changes is a particular chore.

Very early on, then, it was decided that the New York City Health Care for the Homeless Program would offer services by sending health care teams out into the community. In order to reach as many people as possible, the service teams would be mobile, making rounds on a regularly scheduled basis, setting up shop anywhere from a few hours to an entire day each week. The coalition decided to focus on those homeless programs, including soup kitchens and shelters, where services were limited and where clients tended to be particularly needy. It was assumed that those living in the HRA shelter system had easier access to services, either because there were on-site services or because on-site staff could refer them to appropriate services.

Initially, the coalition decided to concentrate on single adults, in the belief that they had the least access to care. Once the program got under way, however, it became clear that homeless families had their own problems with access, and the program gradually began to offer services to them, too.

The architects of the program recognized that in order to provide a full array of health and social services, the traveling teams would have to be interdisciplinary. They envisioned teams that comprised a nurse practitioner or a physician's assistant; a medical assistant; and a social service worker. Together, the team members would provide basic primary care, including physical exams; tuberculosis testing; treatment of hypertension, diabetes, upper respiratory infection, asthma, sexually transmitted diseases, lacerations, and skin problems. Some assessment and treatment of gynecological problems would be provided, depending on the degree of privacy afforded at the site, and referrals would be made for prenatal care.

Team members would also assist homeless people in securing entitlements, especially Medicaid, for which both homeless single adults and homeless families are eligible in New York State. Many homeless people do not apply for aid, however, either because they do not know they are eligible or because they are distrustful or fearful of negotiating the system, which can baffle even the most determined. Without Medicaid, homeless people have limited access to the full range of health services. With Medicaid, they can be

mainstreamed into the health care system, which in turn may promote more independent functioning.

In order to solve this problem, the coalition secured an expedited procedure for obtaining Medicaid. This procedure, which was approved by the New York State Department of Social Services as a demonstration program for Alternate Documentation for Medicaid, enables the team social worker to apply for Medicaid on behalf of a client without all of the traditional documentation. This arrangement has dual benefits: clients become eligible for the full range of health care services, and the program becomes eligible for Medicaid reimbursement, a critical step if the program was to become self-sustaining.

Each of the teams would be based in a hospital or health center. But since the teams would be providing services at many different sites, often not within the neighborhood served by their back-up institution, the planners recognized that arrangements would have to be made with local hospitals and community health centers near the outreach sites for special services and ancillary tests. Eventually, over 30 primary care facilities became part of the back-up network.

But bringing services to homeless people was only the first step. Based on their experience, the planners knew that homeless people are often reluctant to accept care, having experienced repeated failures of the social service system, including educational, penal, mental health, and health care institutions, both prior to and during their homelessness. In fact, many homeless people--either fearful or skeptical--actively shun service providers.

Homeless people with little or no privacy may want to avoid the intimacy necessitated by health care services. Health professionals may ask histories and questions, the answers to which may be difficult or painful to recall. Some homeless people fear that health care professionals will be judgmental or even punitive. Mothers with substance abuse problems often want to avoid professionals who might report them for child abuse or neglect. Battered women may be embarrassed to confide in strangers. And some mentally ill people avoid all close contact as part of their illness.

It was therefore clear to the coalition members that the health care professionals would have to be particularly sensitive to homeless people's reluctance to seek care and actively reach out to engage them and gain their trust. The team members would have to understand the unique and profound rejection experienced by homeless people. Homeless people are shunned; it is therefore not surprising that they find ways to isolate and protect themselves from the world, avoiding even those who may be trying to help. It was this barrier that the planners were most concerned about, and most determined to overcome.

The First Five Years

Once the New York City Health Care for the Homeless Program was approved and an administrative structure was established, the program contracted with three health care institutions, which in turn hired the interdisciplinary teams.* The next step was choosing the sites, each of which had to have sufficient numbers of homeless people in need of services, staff that could support the teams' efforts, a modicum of privacy for medical encounters,

* The number of teams and back-up institutions expanded to seven in 1987, when federal funding was received, and contracted to four in 1990, because of reductions in federal funding.

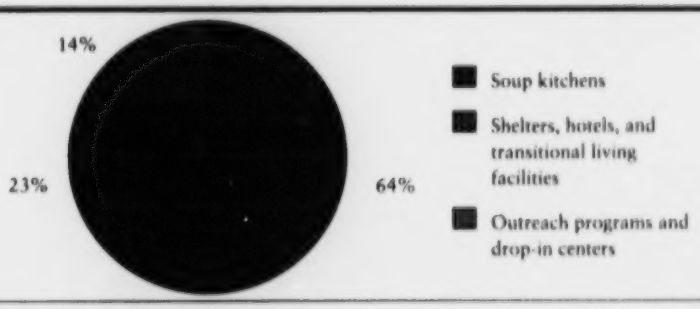
access to running water, and a measure of stability. The appendices list the sites and back-up institutions that have participated in the program.

The program's success in overcoming the barriers to care is demonstrated by a few simple numbers: in 1989 the teams provided services to over 7,900 homeless men, women, and children in almost 20,000 encounters in four boroughs of New York City. The majority of clients served by the program in 1989 were seen at soup kitchens (Exhibit 1). A survey of these clients revealed that approximately 40 percent lived on the streets, in a park, or in the subway; 34 percent lived in public or private shelters; 13 percent doubled up with friends or relatives; 4 percent stayed in single-room occupancy (SRO) hotels; and 4 percent admitted to living in abandoned buildings. The housing status of 9 percent of the sample was unknown.

Data collected by the program confirm that homelessness in New York City is disproportionately and overwhelmingly a problem for young blacks and Hispanics, a finding that should surprise no one but outrage all. Seventy-three percent of the people seen in 1989 were black, 19 percent were Hispanic, and 7 percent were white (Exhibit 2). Most of those seen by the teams were between 20 and 44 years of age (Exhibit 3), and 62 percent were male.

The last five years' experience has endorsed the logic of providing services on the homeless persons' own turf. The informality of the setting helps to break down barriers. Soup kitchen guests or shelter residents can observe a caring, sensitive staff that comes regularly and dependably to places where homeless people congregate, places that many people shun, certainly places not usually visited by professionals. Service providers are

Exhibit 1
Where Clients Were Served
New York City Health Care for the Homeless Program
1989



Note: Figures do not add to 100 due to rounding.

Source: United Hospital Fund, New York City Health Care for the Homeless Program

Exhibit 2
Race, Ethnicity, and Gender of Clients
New York City Health Care for the Homeless Program
1989

	Male	Female	Total
Black	45%	28%	73%
Hispanic	12	7	19
White	5	2	7
Total	62	37	

Note: Figures do not add to 100 percent due to rounding.

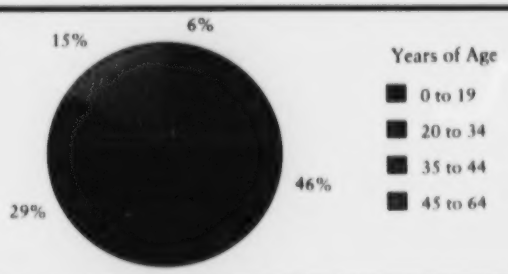
Source: United Hospital Fund, New York City Health Care for the Homeless Program

informal and friendly; gradually, it becomes easier for a homeless person to believe that the outreach workers want to be of assistance. Even more important, guests learn from other guests that "those people" care. They say, "Talk to Edsel or Dawn or John or Hans--she or he can help you."

Staff have learned how to actively engage clients, guests, or residents. Team members "work the line" at a soup kitchen, getting to know people and telling them who they are and what they can do; they move around the tables explaining what services they have to offer and inviting the guests to come to talk to them. At welfare hotels and transitional shelters, staff knock on doors, circulate flyers announcing services, and plan events such as blood pressure screenings that introduce people to the services provided in a non-intimidating fashion.

Although the prevalence rates vary somewhat, homeless people have the same range of health problems as housed people (Exhibit 4), and staff treat them with a range of medications, including antibiotics and ointments. Staff also provide basic health education and referrals. In the shelters, they can issue passes so that people can have bed rest when

Exhibit 3
Clients by Age
New York City Health Care for the Homeless Program
1989



Note: Figures do not add to 100 due to rounding. Clients 65 and over represented 2 percent of total. The age of 1 percent of the clients was unknown.

Source: United Hospital Fund, New York City Health Care for the Homeless Program

Exhibit 4
Most Prevalent Diagnoses
New York City Health Care for the Homeless Program
1989

Females, All Ages	Males, All Ages	Children, 0–14 Years of Age
Upper respiratory infection	Upper respiratory infection	Upper respiratory infection
Pregnancy	Dental problems	Otitis media
Bronchitis	Hypertension	Asthma
Asthma	Rash	Rash
Rash	Asthma	Pharyngitis, strep throat
Hypertension	Bronchitis	Conjunctivitis
Vaginitis	Laceration	Anemia
Anemia	Sprain, strain	Dental problems
Dental problems	Visual problems	Bronchitis
Sprain, strain	Peptic ulcer	Abrasion/Abdominal pain*

* The prevalence rates for these diagnoses were identical.

Source: United Hospital Fund, New York City Health Care for the Homeless Program

appropriate. However, they are powerless when it comes to arranging bed rest and convalescent care for those people seen in soup kitchens, drop-in centers, or outreach programs.

This sense of powerlessness pervades many of the teams' efforts. For example, there are stark limits to how much the medical staff can do to improve the health status of their clients when the very condition of homelessness causes and exacerbates illnesses. Airborne pathogens spread easily in the crowded, poorly ventilated spaces in which many homeless people are sheltered, a fact that may account for the high rates of respiratory infection. Chronic conditions such as asthma and hypertension are exacerbated by the stresses of homelessness. And while pregnancy is not a disease, pregnancy among homeless women must be considered high risk, given their precarious living arrangements. Those homeless people who live on the streets and in abandoned buildings have no access to running water, making it impossible for them to bathe regularly, brush their teeth, or wash their clothes. Strains and sprains are often caused by the fact that homeless people carry heavy loads--sometimes all of their possessions--for long periods of time.

Nonetheless, staff persist. Each team visits its assigned sites once or twice a week on a given day and at a specified time. If it's Monday, the Montefiore team sets up shop at the Love Kitchen of Love Gospel Assembly at 183rd Street and the Grand Concourse in the Bronx, a soup kitchen that serves 600 meals a day. Old-timers know the team well and encourage new people to see them. The "maitre d'" Curly welcomes the guests, seats them in the dining room, and sends people over to be seen by team members. The social worker and the psychiatric nurse see people at a table in a corner of the dining room; and the nurse practitioner and medical assistant set up the portable examining table and supplies in a restroom.

Monday also finds the team from Booth Memorial Hospital setting up at the Jamaica Armory, an HRA shelter for 65 homeless women in Queens. Here the team works closely with the shelter staff, having learned that the effectiveness of the program depends on cooperation between the team and volunteers and staff at the site. To the extent possible, the team incorporates on-site staff and volunteers in its efforts, at the same time adapting its style and practice to the philosophy, policies, and religious beliefs of the host agency. Examples of adaptation range from the mundane--Do the sponsors want to feed people before or after they see team members?--to the more sensitive and political--Will the host object if condoms are distributed? What about bleach kits for cleaning needles? Many sites incorporate prayer or religious services, and team members must be comfortable in such an atmosphere.

Team members must also work closely with the volunteers or staff to be sure that people who need to be seen again come back for services. Without breaching professional confidences, the outreach staff ask volunteers, staff, and guests or residents at sites to encourage specific people to come back to see team members on the days the team is at the site. At those sites that have their own social services, the team coordinates its work with their efforts. In some instances, shelter staff and the outreach team meet on a regular basis to discuss specific clients or the coordination of services. For example, together they may decide that the team's social service staff should lead a group discussion on parenting while on-site staff focus on concrete case management issues such as entitlements and housing.

Team members have learned how to cope with clients who are reluctant to follow up on referrals, either because the clients decide, quite understandably, that something else is more important, such as finding food and shelter, or because they are fearful of what will happen to them at the institution. One team saw a 30-year-old woman with a large lump on her neck, which they diagnosed as lymphoma. "Florence" accepted the primary care services that the team had to offer but would not accept linkages to hospital clinics. After she had broken several appointments, Florence revealed that she was afraid and felt that there was little hope for her. The team eventually persuaded her to go with them to the hospital and

meet with the supervising physician. Florence is now enrolled in the clinic and receiving care.

Medical diagnoses do not always tell the whole story, however. One team saw a 25-year-old mother who was living with her 5-year-old mentally retarded daughter in a welfare hotel in an isolated section of the city. The mother, depressed by her surroundings, was unable to take her child to her special school. The team social worker was able to persuade the public welfare agency caseworker to move the mother and daughter to a more appropriate Tier II facility with supportive services. The mother recently returned to the hotel to thank the team and tell them that she and her daughter were doing well.

This is only one of the social services the team is prepared to provide. Other examples include the expedited procedure for obtaining Medicaid and referral for other legal entitlements. Staff, familiar with the wide range of referral agencies, help clients to resolve legal issues, including those related to immigration and political asylum, and help them to obtain housing, clothing, food, and identification. Those clients seeking employment are assessed for work readiness, education, and training needs, and linked to the appropriate resource.

Sometimes the teams can help simply by linking clients with other homeless service providers. For example, one team engaged "Sylvia," a 55-year-old woman who reported being depressed because she was so much older than the rest of the residents in the shelter where she had lived for two-and-a-half years. The team provided support and counseling and linked her with a mental health outreach program. After several months of working with the team and with other mental health professionals, Sylvia was admitted into an appropriate adult home.

The Biggest Challenges

Looming over all else are those problems that confront all health care providers in New York City: substance abuse, AIDS, and mental illness.

Substance Abuse. Given the stresses of life on the streets of New York and the losses that invariably accompany homelessness, it should surprise no one that substance abuse is the most prevalent diagnosis for adults. However, the abused substance varies significantly between age groups (Exhibit 5). In 1989, crack use was more than twice as prevalent as alcohol abuse among the younger clients, while alcohol was clearly the substance of choice among the older clients. The prevalence of heroin abuse was relatively low among both age groups, a sign that patterns of drug abuse have indeed changed significantly over the past 20 years.

Exhibit 5
Chemical Dependency among Clients by Age and Gender
New York City Health Care for the Homeless Program
1989

	Male		Female		Total
	20–44 Years of Age	45–64 Years of Age	20–44 Years of Age	45–64 Years of Age	20–64 Years of Age
Crack	25%	7%	25%	6%	22%
Alcohol	16	36	8	14	16
Cocaine	14	7	9	4	11
Heroin	10	7	9	5	9
Methadone maintenance	2	2	3	2	2

Source: United Hospital Fund, New York City Health Care for the Homeless Program

When appropriate, team members link clients with substance abuse treatment programs, including detoxification programs, therapeutic communities, acupuncture clinics, and twelve-step programs, such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous. One team has been particularly resourceful in linking clients with substance abuse programs outside of New York City, where there seems to be a greater availability of detoxification and treatment beds. Often, however, clients deny the serious nature of their substance abuse problem, and in these cases staff members try in a nonjudgmental way to motivate clients to seek help. The biggest challenge here is to give people a sense of hope and to persuade them that they can control at least some aspects of their lives. Of course, substance abuse is rarely the only problem, and staff members must often work with clients to resolve other issues before focusing on the substance abuse problem.

For example, one team in the Bronx treated "Carmen," a woman who had become homeless because of a fire. Team members obtained Medicaid for Carmen and linked her with a substance abuse program. Later they worked with her to have her daughter returned to her from foster care. Mother and daughter are currently living together in a transitional family residence. The daughter is doing well in school and Carmen is working on obtaining a high school equivalency diploma. Her next step is to secure a job and an apartment. Given Carmen's circumstances and history, each step is a giant one.

In another case, outreach staff worked with "Leroy" over a seven-month period to resolve problems related to alcoholism, neurological impairment, and public assistance. At one point, the team arranged for hospitalization when Leroy suffered a heart attack. When the team saw him three months later, Leroy was well groomed, had a steady gait, had been free of alcohol for three months, and was living in a stable environment with his family. Leroy's story is a success story.

HIV Services. AIDS is a growing problem among homeless people in New York City, especially among intravenous drug users, crack abusers, and their partners.

Staff of the New York City Health Care for the Homeless Program intervene in a number of ways with clients who are at risk for HIV infection and those who are HIV positive. The staff's primary goal is to motivate clients with substance abuse problems to enter treatment. However, if clients are not ready to give up their drug dependency, staff advise them about the dangers of sharing needles and having unprotected sex. The teams have shown educational videotapes at various sites. One team has worked with the New York City Department of Health's Bridge to Treatment Program, which piloted an AIDS education and needle exchange program. All staff have been trained to do pre- and post-test counseling. The staff also distribute condoms, which they pick up in lots of 1,000 from the New York City Department of Health, and report that clients are requesting them with increasing frequency.

Since HIV infection can affect the way other diseases manifest themselves, staff have received in-service training by an internist and dermatologist on the ways in which other diseases and dermatological problems can affect the immunocompromised patient. Staff have succeeded in getting some patients on AZT, but they find that other clients--fatalistic about their condition--are reluctant to seek early treatment. In this bleak picture, there are occasional bright moments: One client that the staff treated with AZT was well enough to attend last year's "Housing Now" march in Washington, D.C.

The teams' social service staff have been working with the New York City HRA AIDS Management Unit to obtain housing for clients, but they have had limited success, given the large number of cases the city must serve. In the meantime, they provide supportive counseling to clients who have had very little good fortune and now face a terminal illness.

Mental Health. Of the clients seen by the New York City Health Care for the Homeless Program in 1989, 10 percent were diagnosed as mentally ill. The actual prevalence is

probably significantly higher, but it is difficult to make mental health diagnoses in the field given the tendency for homeless persons to self-medicate through alcohol, illegal drugs, and misuse of prescription drugs, all of which obfuscate the real problem. Although the program has not collected data on the mentally ill chemical abusers that are seen, there is general consensus that they comprise a large part of the homeless population. Team members focus on identifying and assessing mental health needs, motivating clients to accept services, and linking them with the appropriate service.

In one situation, a psychiatric nurse intervened after observing a bitter argument between a shelter staff person and a new resident. The nurse gradually learned that "Pearl" had been thrown out of the window of her apartment by her husband, who later killed their children. After months of being comatose, Pearl was discharged from the hospital. Upon failing to continue in psychiatric treatment, she became homeless and was easily provoked to anger, which had necessitated a transfer from another shelter. With the help of psychotherapy, Pearl has learned to express her anger more appropriately and to take control of certain aspects of her life, rather than let her tragic past dictate her future.

Supporting the Outreach Staff

Because of the demanding nature of the work, it is important to build adequate support systems for the outreach staff. The program seeks to do this by holding regular staff meetings, offering in-service training, and encouraging frequent telephone contact between team leaders and Fund staff. Staff training has focused on substance abuse; AIDS; psychiatric issues; and family concerns, such as child development and abuse, post-natal experiences of crack babies, and domestic violence. Training in group leadership, parenting, teamwork, and outreach skills has also been offered.

Besides building knowledge and skills and providing support, staff meetings strive to prevent isolation and to build a commitment to the program and the "cause." Staff are encouraged to educate their medical and social service colleagues about their work by speaking and presenting papers at professional conferences; they also train new workers and students who rotate on the teams. Administrators at the various institutions are urged to provide support to the teams, in order to build morale and commitment to both the institution and the program. This administrative support is especially important because the mobility of the team makes it difficult for team members to feel as if they are an integral part of the clinic or hospital.

HOLES IN THE SAFETY NET

The New York City Health Care for the Homeless Program has had a certain amount of success in reaching those homeless people with the least access to health and social services, but there have been limits to the kind and amount of services the teams can provide, due to the limitations in sites and the nature of homelessness itself.

Limitations in Sites

The greatest strength of the program--its mobility--is sometimes a drawback. Because staff must travel from site to site and set up for short periods of time, often in the middle of the day, it is difficult for them to be as productive as traditional clinic workers. For instance, if a team has to be at one soup kitchen at 11:30 A.M., it is difficult for the team to provide services elsewhere before then. And since soup kitchens are run by volunteers, they are open for a very brief time with the object of getting as many people as possible in and out in

an hour or two. Sometimes the space available to feed people is so small that there are multiple sittings, an arrangement that leads to even more haste than usual.

In some instances, the program has been unable to serve some otherwise desirable agencies or soup kitchens because they had no appropriate space. Sites do not always offer sufficient privacy, quiet, cleanliness, ready access to water, or access to a phone for making referrals and setting up appointments. Sometimes, even places that are appropriate and wish to participate are prevented by other considerations: one church that sponsored a soup kitchen was told that its liability insurance premium would be increased if health services were provided on site. Other times, more selfish financial considerations prevail: hotel owners view donating a room for providing health care and social services as lost rental income and most often refuse to make such space available.

Providing services exclusively in the rushed atmosphere of soup kitchens can be frustrating, not only for clients but also for team members, who find that often they cannot spend enough time with clients. As a result, although the program continues to see clients at soup kitchens, it now also provides services at shelters for single adults, families, and the elderly; a multiservice homeless provider; a street outreach program; and a drop-in center. The variety of sites gives team members the opportunity to provide more continuous services and to serve a more diverse caseload, both important factors in ensuring some measure of job satisfaction. In many instances a team is able to spend an entire day at a shelter, which enhances productivity and reduces the stress associated with packing up and moving on.

Caring for Those Who Are Reluctant to Receive Care

In determining the level of care to provide, physicians and mid-level practitioners must make some difficult decisions. At some sites, the lack of privacy makes it impossible to discuss confidential matters or to provide gynecological services, and clients must be referred to back-up facilities. At the same time, providers must assess how likely the client is to return for follow-up visits or to follow through on a referral to a back-up facility. If the patient has a poor history of follow-through, the practitioner may decide to treat the patient based on the presumptive diagnosis.

Both medical and social service staff have to deal with the tension of providing services to clients who may want help with one aspect of their life when the professional thinks the primary problem lies elsewhere. For instance, what does one do with a person who requests help with employment when chemical dependency is interfering with all aspects of the person's life and may lead to failure on the job? Staff struggle to respond to the client's needs but at the same time try to serve as an objective voice.

Staff also seek to strike a balance when it comes to promoting clients' independence. Recognizing that many of the people they serve have never been able to count on anyone and that one of their unmet needs is some healthy dependence, staff must decide how much and what to do and to what extent to focus on encouraging and instilling a sense of independence.

Success in this area may bring some unanticipated challenges. When service providers encourage people to take charge of their lives, they empower them, and it is inevitable that some of this new empowerment will be expressed against the service provider as well as the system. Service providers can easily become frustrated by clients' criticism. It also happens that homeless people, like any group that is constantly being told what to do, may express their need to take control of their lives in the one way they can: by refusing services. Staff must be encouraged to discuss and evaluate the meaning of such expressions as they appear collectively and with individual clients. Workers can easily feel rejected and need the support of supervisors and administrators in coping with "hostile" clients.

Changes in Staffing Patterns

Recruitment of staff has become increasingly difficult in light of the general shortage of health care professionals and society's apparently waning commitment to serving the poorest of the poor. While salaries are kept competitive with existing institutional salaries, the work is unusually demanding and draining. It requires staff who are competent, enjoy problem solving, and are committed to people with special needs. Many of the staff come from a strong religious or socially conscious political background.

The shortage of health care personnel has caused the program to reconsider its staffing model. Unable to recruit master's level social workers for all of the teams, the program has instead employed carefully screened bachelor's level social workers, who have proven extremely resourceful and insightful. Similarly, because of the shortage of mid-level practitioners, physicians are now employed at some outreach sites to provide primary health care.

There have been other changes in the staffing of the teams. When the program expanded in 1988, teams grew to include an outreach worker whose primary responsibility is, aptly enough, reaching out and engaging people. The outreach worker also provides most of the casework for concrete resources such as Medicaid and other entitlements. In another change, one health center decided to integrate the program into its own program and placed physicians at outreach sites for either one half-day or one day per week as part of their regular assignment. This has allowed the physicians a more varied work assignment and helped ensure that they are an integral part of the health center.

But although the program has managed to adapt to the shortage of professional staff, the problem points to disturbing weaknesses in our professional educational system. The shortage of health care professionals who are willing to work with homeless people--in particular those homeless people with mental health or substance abuse problems or with HIV-related illnesses--is unlikely to disappear until professional education is restructured in such a way that people who are dedicated to the idea of serving special populations are actively recruited, until the financing of professional education makes it possible for students to follow through on their altruistic motives, and until professional education itself stresses the importance of caring for special populations.

Institutional Aversion to the Homeless

While many hospitals and health centers have welcomed the program's clients and referrals, others have been less accommodating. To be fair, institutions in New York City are already overwhelmed by too many demands and too few staff and resources; many institutions, already financially troubled, cannot lightly take on additional patients for whose care they may not be reimbursed; and institutions understandably worry about hospitalizing someone who has no appropriate place for discharge and who, therefore, may add further to institutional overcrowding. Nonetheless, it is--to say the least--distressing that some health care institutions have so far forgotten their mission that they do not welcome referrals, fearing that homeless people will scare away other, more "deserving" patients as well as physicians.

In order to combat these stereotypes, the program has worked with a variety of institutions, through individual consultations and Fund conferences, to educate professionals and to assist institutions in being more responsive to homeless people.

Lack of Convalescent Care Facilities

All too often, a homeless person who has been appropriately hospitalized for an acute illness has no appropriate place to which to be discharged once the immediate medical problem

has been satisfactorily treated. Nonetheless, the person is not ready to manage on the street or in a shelter. Currently within the HRA system in New York City, there are only 15 infirmary care beds for men, 3 beds for women, and 87 for men with tuberculosis. Even when there might be an available bed within the HRA shelter system, many homeless people will not accept a referral to an HRA shelter because they are fearful of violence and abuse in the shelter system. At the same time, there are also homeless people being treated at soup kitchens, drop-in centers, and mental health outreach programs who need a place to convalesce who also refuse to go to shelters or for whom there is no infirmary bed.

IMPLICATIONS FOR PUBLIC SOCIAL POLICY

It is clear from the lessons of the New York City Health Care for the Homeless Program that health care can be provided to homeless people on their own turf in a sensitive, realistic way, and efforts to do so must continue. Nonetheless, it is important not to lose sight of some of the larger issues underlying homelessness: racism, debilitating cutbacks in mental health services, the rise in substance abuse, and lack of adequate low-income housing.

Racism

Society has clearly failed to integrate large segments of minority youth into the mainstream of American life. The fact that homelessness disproportionately affects minorities is hardly by chance. They are without doubt the victims of racism, a failed educational system, the staggering economy, and family disintegration. Clearly, we have failed to offer our own minority youth the same opportunity to succeed that millions of immigrants have sought and often found. Without some new commitment to these young people, without sufficient programs to give these young people the skills they need to compete in a market place economy, we will face years of more and more disenfranchised and angry people on the streets and in the parks across our nation.

Mental Health

The short-sightedness of the deinstitutionalization policies of the 1960s and 1970s is by now well established: the community-based programs that were to maintain mentally ill people in the community with dignity never materialized. While many deinstitutionalized persons survived in SROs with limited or no services, the final blow to this vulnerable population--the loss of SRO housing--was dealt by the real estate market. In addition, in 1982 many mentally ill people lost their Supplemental Security Income (SSI) benefits as a result of an administrative review by the Social Security Administration. The loss of income threw still more vulnerable people onto the streets. Many of these benefits were later restored in appeals, but by then many people had become homeless and the damage had been done.

As a result of these changes, the mental health sector in New York is overburdened, and the amount of available treatment is dwarfed by the need. The homeless mentally ill are perhaps the most powerless and vulnerable citizens in our society. Due to their mental illness, they become isolated and have limited contact with the larger society, and many of their mental disorders escape detection. There is an urgent need for outreach, assessment, counseling, support, and, when appropriate, linkage to more intensive programs. Outreach services must target those many homeless people for whom mental illness and substance abuse are intertwined and offer them treatment and rehabilitation.

While the city and state fund a number of outreach and case management services for mentally ill homeless people, there is a still a significant gap between what is available and

what is needed. Adequate services must be provided for those persons whose mental health status may necessitate supportive or supervised living arrangements, in order to prevent them from returning to homelessness. Furthermore, public agencies, which until now have focused on the needs of homeless single adults, must pay more attention to the not insignificant needs of homeless family members.

Substance Abuse

Whether people become homeless because of substance abuse or whether homeless people turn to substances to anesthetize the squalid conditions of their lives, the fact is that significant numbers require treatment for abuse of substances. Because of the shortage of treatment slots and beds, homeless people need aggressive intervention and advocacy to gain access to needed treatment.

Until a year ago there had been no organized attempts on the part of the homeless advocacy and service providers to work cooperatively with the substance abuse community. In 1989 the New York State Division of Substance Abuse was awarded a federal grant to convene homeless advocates and service providers together with chemical abuse providers. The consortium sponsored a conference in April. The first of its kind, the conference was attended by over 400 line workers, administrators, and policymakers in the field of homelessness and substance abuse. The consortium is in the process of discussing the formation of a group to promote cooperation and to recommend policy and programmatic changes; the goal is to make the services currently available more responsive to chemically dependent homeless people.

Program designers, policymakers, and funders need to take into consideration not only the substance abuse problem but also educational and vocational needs, skills for independent living, discharge planning, housing resources, and community-based follow-up services. Those who have been in treatment for substance abuse must be helped to gain access to affordable housing; certainly, they should not *lose* access to permanent housing because they have to leave the shelter system for treatment.

More programs are needed that treat the family as a whole. Programs need to be developed that do not disrupt family life by necessitating the separation of parents from their children. In the past some women who gave up their children while in treatment experienced problems negotiating their return from the Child Welfare Administration, getting the appropriate housing allowance from welfare and income maintenance offices, and obtaining housing. While HRA has sought to remedy this situation, women still need caseworkers who will help them navigate the system. Parents who have already lost custody of their children because of their substance abuse problem need to be prepared for reunion with their children and for the resumption of their parental responsibilities.

Recently, one Tier II facility established a program for chemically dependent parents. Unfortunately, the current length of stay in the Tier II facilities is too short for this treatment process. If the current movement out of the Tier II facilities to permanent housing continues, however, it may be necessary to create new incentives to encourage completion of treatment prior to community-based treatment. But before such programs can get under way, service providers, housing groups, and policymakers must come to agreement about the proper role for Tier II facilities.

Again, if treatment programs are to avoid becoming expensive revolving doors, they must take the substance abuser's housing status into consideration. Until recently, with the exception of some special programs for Bowery alcoholics, there have been virtually no special treatment programs for homeless substance abusers. However, the very fact that a

homeless person is coming from the streets and has no permanent residence to return to has implications for discharge and after-care. While there is no hard evidence, it is also possible that for those people who have been homeless for a long time, the toll to their self-esteem and coping mechanisms may require some additional treatment or consideration in order to optimize their chances for recovery.

HIV Services

AIDS threatens to overwhelm the entire health care delivery system in New York City. Hard as it is to imagine, the next decade will be even worse, as the epicenter of the epidemic shifts--from the male homosexual population to the population of intravenous drug users and their partners, from largely white, well-educated, middle-class men to poorer men, women, and children of color. As people with HIV-related illnesses begin to live longer, the entire configuration of services must be rethought. People in the later stages of infection require a range of outpatient, inpatient, day care, home care, and skilled nursing home services, as well as intensive case management.

In order to cope with the growing number of HIV-infected homeless people, the Division of AIDS Services within HRA must significantly increase its ability to provide humane and decent housing alternatives. HRA is currently developing a continuum of care plan to serve homeless people in various stages of need, with the immediate focus on specialized units within the existing shelter system. This continuum of care plan includes scattered site apartments, comprehensive care programs in the shelters, and supportive housing. Group residences will undoubtedly be needed, as well. Unfortunately, the city is faced with serious problems developing the housing and scattered site apartments because of community opposition.

Once HRA has expanded its AIDS services and developed additional housing resources for homeless people, these formerly homeless people will need case management services, help with entitlements, and the range of home care services in order to maintain them in the community. The Division of AIDS Services, already pushed to the limit, will be increasingly faced with the challenges of recruiting, training, and retaining case management staff.

Need for Housing

First and foremost homeless people need low-income housing. While the federal government has nearly abandoned its responsibility for subsidized housing, local governments have picked up some of the slack. In particular, New York City and New York State have taken major steps to renovate abandoned real estate stock. In New York City alone, 20,000 apartments have been rehabilitated for homeless people, using several different models that combine public and private support and management.

Low-income housing alone will not do the trick, however. Some homeless people need special supportive services in this new housing to help them establish themselves in new neighborhoods and in their own housing, many of them for the first time. Others, such as those who are chronically mentally ill, may need supportive living arrangements for their lifetime.

While local initiatives like New York City's and New York State's are commendable, most service providers and housing experts agree that the crisis will not abate until the federal government renews its commitment to low income housing at a level sufficient to "house" the currently homeless, to replace low income housing that has been lost to

gentrification and other market pressures, and to maintain existing housing stock at reasonable levels.

Health and Social Services for Homeless People

Once society solves the problems outlined above--racism, mental illness, and substance abuse--there may be very little need for health care and social services for homeless people. In the meantime, there are several policy issues of particular relevance to homeless people.

Outreach Services. First, outreach professionals must be able to link homeless people with the full range of health care provided at health centers, outpatient clinics, and emergency rooms. The outreach and receiving professionals must be trained in the diagnosis and treatment of health conditions that are prevalent among homeless people, and outreach professionals should be given adequate support and encouragement at their own institution so that they do not become the pariah of the health care community.

Health care services, however, cannot be provided in a vacuum. Public agencies, both local and federal, must strengthen outreach services in order to gain for homeless people the entitlements for which they are eligible. Casework services need to be adequately funded so that caseloads are manageable; casework staff must be given adequate training and supervision; and casework services must be available to persons after permanent placement to facilitate and ensure continued integration into the community.

Funding. Programs need to be able to count on consistent and adequate funding. In reality, under the Stewart B. McKinney Homeless Assistance Act, federal appropriation levels have varied from year to year. Some programs have been forced to cut back, leaving administrators frustrated and embarrassed, the staff unsure of their jobs, and homeless service sites uncovered. For example, the New York City Health Care for the Homeless Program was forced to cut back from seven teams to four in 1990 as a result of insufficient federal funding, and the program was forced to curtail services at some sites. Another problem has been the federal government's requirement that programs obtain matching funding, an onerous requirement for some programs.

Convalescent Care. The shelter system is not set up, nor should it be, to provide refrigeration for insulin, privacy for cleaning colostomy bags, or salt-free diets for persons with

Exhibit 6
Most Common Conditions Requiring Convalescent Care for Clients New York City 1989

Medical Condition	Examples	
Problems with extremities	Fracture, ulcer, abscess, tendinitis, gunshot/stab wounds	41%
Respiratory ailments	Bronchitis, tuberculosis, common cold, flu, pneumonia	13
Post-surgery		8
Hypertension		5
Diabetes		5
Cardiac problems	Angina pectoris, conjunctive heart failure	3
HIV-related illnesses		3
Other	Seizures, substance abuse problems, need for supervised medication	20

Note: Figures do not add to 100 percent due to rounding.
Source: United Hospital Fund, New York City Health Care for the Homeless Program

hypertension, to name just a few of the needs of those suffering from chronic ailments. Simply put, the shelter system was set up to house people on a temporary basis, not to provide a substitute home.

In the summer of 1989, under the auspices of the Committee on Infirmary Care of the New York City Coalition for Health Care for the Homeless, program staff conducted a survey in an attempt to quantify the need for convalescent care among homeless single adults. The study defined a person as needing convalescent care if he or she required bedrest, leg elevation, or monitoring for one month or less. If the sample seen in the survey is close to representative, at least 747 single homeless adults in New York City are in need of convalescent care at any given time (Exhibit 6).

Facilities must be developed in which homeless single adults can safely convalesce from subacute illnesses and temporary exacerbation of chronic illnesses. These facilities should be small and dispersed geographically in order to accommodate homeless people near where they live. Referrals should be made by outreach health professionals serving homeless people, as well as by staff in emergency rooms, clinics, and hospitals. Such facilities should be designed for persons with temporary disabilities and should not be construed as a substitute for appropriate long-term care or housing.

CONCLUSION: PRESENTING A UNITED FRONT

Perhaps the largest problem of all in reaching homeless people with a comprehensive package of health care services is the tremendous fragmentation of approach. There have been too few examples of cooperative working relationships. Although everyone wants the same thing in the long run--to help homeless people--they often disagree about how to attain that common goal. For example, in their attempt to garner support for homeless people, advocates often enter into litigation against the very public agencies that are doing their best to cope with the problem. For their part, agencies are often constrained by limited resources. The "recalcitrant" bureaucrat may simply be one whose hands are tied. These problems are compounded by the diversity of funding streams, which only increases the fragmentation of approach.

The need to work together is particularly pronounced in the light of the resistance that has sprung up in communities across the city and state. Although the number of homeless people is not declining, homeless people seem to have become yesterday's cause, and objections to sites devoted to serving the homeless are becoming increasingly vociferous. If advocates and public administrators, public and private agencies, line workers and policymakers could make an initial leap of faith and learn to trust each other, they could devote their energies to designing humane and appropriate services and to developing the public's support for such programs.

Finally, we must not forget the hundreds of people who work tirelessly with homeless people on the streets, in soup kitchens, and in shelters. These people are the eyes, ears, and heart of our collective social conscience; without them, the plight of homeless people would be even worse than it is. By giving of themselves with little reward, these workers are doing the work of a society that has failed large segments of its population. Their example should inspire us to find ways to right the wrongs that have caused this pernicious problem.

APPENDIX 1: SITES SERVED BY THE NEW YORK CITY HEALTH CARE FOR THE HOMELESS PROGRAM

The following list shows the sites served by the New York City Health Care for the Homeless Program since 1985. The site name is followed by the name of the sponsoring organization, if there is one.

Bronx

Kingsbridge Armory Shelter for Women*
New York City Human Resources Administration

Love Kitchen*
Love Gospel Assembly

Paradise Hotel

Part of the Solution (P.O.T.S.)*

Powers Family Residence*
New York City Human Resources Administration

Prospect Inn
Homes for the Homeless

Queen of Peace

St. Paul's Church
Planning Association of Bronx Lutheran Churches

Salvation Army, 159th Street

Shearson Lehman Hutton Residence
Women in Need

Shiloh Church

Thorpe Family Residence*
Dominican Sisters

Brooklyn

Berean Baptist Church

Bond Street Drop-In Center*
Catholic Charities

Bread of Life*
St. John the Baptist Church

Bullshipper Hotel

*Current site as of November 1990

Christian Help in Park Slope (CHIPS)

Flatlands Family Residence*
New York City Human Resources Administration

H.O.M.E.
Catholic Charities

Monica House
Women in Need

Most Holy Trinity Church

Our Lady of Presentation Church

Park Slope Armory Shelter for Women
New York City Human Resources Administration

Sumner Avenue Armory Shelter for Men
New York City Human Resources Administration

The Tabernacle Church

Urban Strategies*

Manhattan

All Angels Church*

BRC Human Services, Inc.*

Community Impact
Broadway Presbyterian Church

McAuley Water Street Mission*

Project Contact
Educational Alliance

Project Reachout*
Goddard Riverside Community Center

Queen of Peace/St. Joseph's Church

St. James Episcopal Church*

Soul Saving Station

Valley Lodge*
West Side Federation for Senior Housing

*Current site as of November 1990

Queens

Bethesda Missionary Baptist Church*

Jamaica Armory Shelter for Women*
New York City Human Resources Administration

Mets Motor Inn

Salvation Army, 161st Street

Skyway Hotel

*Current site as of November 1990

APPENDIX 2: CONTRACTED PROVIDERS WITH THE NEW YORK CITY HEALTH CARE FOR THE HOMELESS PROGRAM

The following list indicates the providers with which the New York City Health Care for the Homeless Program has contracted for back-up health services since 1985.

Bedford Stuyvesant Family Health Center*

Betances Health Unit, Inc.

Booth Memorial Medical Center*

Bronx Committee for the Community's Health, Inc.

Family Physician Health Center
Lutheran Medical Center

Institute for Urban Family Health*

Montefiore Family Health Center*
Montefiore Hospital and Medical Center

Paul Robeson Family Medical Center
North General Hospital

Soundview Health Center

Stuyvesant Polyclinic
Cabrini Medical Center

* Current provider as of November 1990

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